POLICY 962, ATTACHMENT A - SECLUSION AND RESTRAINT INDIVIDUAL REPORTING FORM

PROVIDER INFORMATION	
Report Date:	Program/Facility License #: *Click here to enter text.*
AHCCCS Provider ID: *Click here to enter text.*	Program/Facility Name: *Click here to enter text.*
Contact Person Phone #: *Click here to enter text.*	Provider Address: *Click here to enter text.*
Contact Person and Title: *Click here to enter text.*	
Name/Credentials/Title of Person Authorizing the Event: *Click here to enter text.*	
Name/Credentials/Title of Person Re-Authorizing the Event: *Click here to enter text.*	

MEMBER INFORMATION		
Member Name (Last, First, M.I.): *Click here to enter text.*		
Date of Birth:	Age:	Gender:
CIS ID: *Click here to enter text.*	AHCCCS ID: *Click here to enter text.*	
TXIX/XXI Eligible: ☐ Yes ☐ No	Member Behavioral Health Category: *Click here to enter text.*	
DDD: *Click here to enter text.*	CMDP: *Click here to enter text.*	
CRS:	ALTCS E/PD: *Click here to enter text.*	
Name of member's legal guardian/health care decision maker (if applicable): *Click here to enter text.*		
Phone number of member's legal guardian/health care decision maker (if applicable): *Click here to enter text.*		

CURRENT DIAGNOSES	
CODE	**NAME**

CURRENT MEDICATIONS			
MEDICATION	**DOSAGE**	**FREQUENCY**	**METHOD OF ADMINISTRATION**

Effective Dates: 7/01/16, 07/12/17, 10/01/18, 10/01/19
Approval Dates: 04/06/17, 06/13/18, 10/03/19

EVENT INFORMATION

If a Seclusion and/or Restraint occur, complete all that apply. If the member is secluded and/or restrained, complete **BOTH** the seclusion and restraint sections.

EVENT INFORMATION		
Type of Event: ☐ Seclusion ☐ Restraint		
Date:	Time (24-hour clock):	Evaluation/Initial face to face Assessment:
Did Member have medical condition(s) that placed them at greater risk for poor outcomes?		☐ Yes, describe:
		☐ No
Was the reason for seclusion/restraint and the conditions for release explained to the member?		☐ Yes, describe:
		☐ No

DE-ESCALATION METHODS AND ALL LESS RESTRICTIVE MEASURES ATTEMPTED	
Select de-escalation methods and all less restrictive measures attempted prior to seclusion and/or restraint:	☐ Removing member from stimuli
	☐ Encouraging member to express feelings in appropriate manner
	☐ Conflict resolution
	☐ Re-directing the member
	☐ Offering prn medication, when necessary
	☐ Allowing member to pace and vent
	☐ Other (e.g. humor, distraction, 1:1, snack)

PERSONAL RESTRAINT (CHECK BOX)
Date of Administration: *Click here to enter text.*
Type of Restraint (e.g. Physical Hold):*Click here to enter text.*
Time (24-hour clock):*Click here to enter text.* Start time: *Click here to enter text.* End time: *Click here to enter text.*
Duration of Restraint: *Click here to enter text.* Hours *Click here to enter text.* minutes
Name/Credentials/Title of Primary Individual involved in the Restraint: *Click here to enter text.*

MECHANICAL RESTRAINT (CHECK BOX)
Date of Administration: *Click here to enter text.*
Type of Restraint: *Click here to enter text.*
Time (24-hour clock):*Click here to enter text.* Start time: *Click here to enter text.* End time: *Click here to enter text.*
Duration of Restraint: *Click here to enter text.* Hours *Click here to enter text.* minutes
Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.*

MEDICATION USED AS RESTRAINT					
DATE OF ADMINISTRATION	TIME OF ADMINISTRATION	MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION

SECLUSION

SECLUSION
Date of Administration: *Click here to enter text.*
Time (24-hour clock): *Click here to enter text.* Start time: *Click here to enter text.* End time: *Click here to enter text.*
Duration of Restraint: *Click here to enter text.* hours/ *Click here to enter text.* minutes
Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.*

REASON FOR RESTRAINT AND/OR SECLUSION

REASON FOR RESTRAINT/SECLUSION	
Include relevant information to describe facts/behaviors justifying the use of seclusion or restraint. Be descriptive (e.g.'hitting and kicking staff' instead of 'physically aggressive toward staff').	
☐ Danger to Self (DTS)	Member Behaviors: *Click here to enter text.*
	Member Quotes: *Click here to enter text.*
☐ Danger to Others (DTO)	Member Behaviors: *Click here to enter text.*
	Member Quotes: *Click here to enter text.*

MONITORING

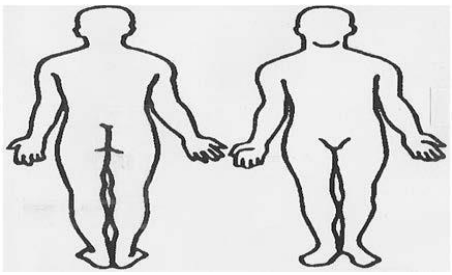
MONITORING				
The member must be personally examined at a minimum of every 15 minutes to ensure the member's comfort and safety and to determine the member's need for food, fluid, bathing, and access to the toilet. If the member has any medical condition that may be adversely affected by the restraint or seclusion, the member shall be monitored every five minutes, until the medical condition resolves, if applicable. Attach internal documentation of face-to-face monitoring for all episodes that require such documentation per A.A.C.R9-21-204, A.A.C.R9-10-225, or A.A.C.R9-10-226. Addendum content must include requirements contained in AMPM Policy 962, Seclusion and Restraint Requirements.				
	Date	Time (24-hour clock)	Name of Primary Individual involved in the Restraint	Credentials/Title of Primary Person involved in the Restraint
Start	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*
End	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*	*Click here to enter text.*

FACE-TO-FACE ASSESSMENT
The member must receive a face-to-face assessment of physical and psychological well-being from the Psychiatrist or Registered Nurse (with one year of behavioral health experience) within one (1) hour of initiation of the restraint or seclusion.
Name/Credentials/Title of Primary Person involved in the Restraint: *Click here to enter text.*
Date of Assessment: ***Click here to enter text.***
Time (24-hour clock) of Assessment: *Click here to enter text.*
Description of Member Condition (orientation, mood, affect, behavior per R9-21-204 (physical and psychological wellbeing)):

CLINICAL JUSTIFICATION TO DISCONTINUE SECLUSION OR RESTRAINT
☐ No risk for danger to self
☐ No risk for danger to others
☐ Improvement of mental status
☐ Medication administration completed

☐ Able to follow verbal commands
☐ Meets all criteria for release

INJURIES

INJURIES	
Was the member physically injured DURING (not prior to) the seclusion and/or restraint? ☐ Yes ☐ No	
If yes, explain the nature of the injury and complete an Incident, Accident, and Death (IAD) Report:	
Explain the level of medical intervention needed (e.g. first aid, physician, hospitalization, death): *Click here to enter text.*	

THIS SECTION MUST BE COMPLETED IF A MEMBER WAS INJURED DURING A SECLUSION AND/OR RESTRAINT PROCEDURE

INCIDENT, ACCIDENT, AND DEATH (IF APPLICABLE)
(The Contractor, TRBHA, or Tribal ALTCS, must ensure timely and accurate reporting of incidents, accidents, and deaths involving members to AHCCCS/ Quality Management.
Date of Incident, Accident, and Death Report completed:
Name/Credentials/Title of All Individuals involved in the Seclusion/Restraint procedure:

DEBRIEFING

MEMBER DEBRIEFING
Date of debriefing: *Click here to enter a date.*
Time (24-hour clock) of debriefing: *Click here to enter text.*
Name/Credentials/Title of primary individual involved in the Debriefing: *Click here to enter text.*
Other participants involved in the debriefing: *Click here to enter text.*
Information discussed during the debriefing: *Click here to enter text.*

STAFF DEBRIEFING
Date of debriefing: *Click here to enter a date.*
Time (24-hour clock) of debriefing: *Click here to enter text.*
Name/Credentials/Title of all staff in attendance in the debriefing: *Click here to enter text.*
Identified intervention opportunities that may have prevented the incident: *Click here to enter text.*
Things that were done well and/or team strengths: *Click here to enter text.*
Ways the team could strengthen their response to future incidents: *Click here to enter text.*
Information discussed during the debriefing: *Click here to enter text.*
Procedures that can be implemented to prevent recurrence: *Click here to enter text.* Systemic changes: *Click here to enter text.* Alternatives for this member: *Click here to enter text.*
Outcome of debriefing (including actions taken to avoid future use of seclusion or restraint and identification or alternatives to seclusion and restraint on individual and systemic levels): *Click here to enter text.*

FOLLOW-UP

FOLLOW-UP		
Was the treating provider notified?	☐ Yes, Name of provider: ☐ No (If no, explain):	Date of Notification: *Click here to enter text.*
Was the family/guardian/health care decision maker notified?	☐ Yes, Name and relationship of the person notified: ☐ No (If no, explain):	Date of Notification: *Click here to enter text.*
Were the findings of face-to-face monitoring and nursing assessment discussed?	☐ Yes, with whom: ☐ No (If no, explain):	Date of Discussion: *Click here to enter text.*
Was the need for other interventions or treatments reviewed?	☐ Yes, with whom: ☐ No (If no, explain):	Date of Review: *Click here to enter text.*
Were revisions made to the treatment plan or scheduled?	☐☐ Yes, Describe revisions: ☐ No (If no, explain):	Date of Revisions:

Were Seclusion and Restraint orders completed? Check all boxes that apply and attach orders when submitting Seclusion and Restraint form.	☐ Initial Order ☐ Continuation Order ☐ Discontinuation Order
Were monitoring sheets completed (every 15 minutes or every 5 minutes)? Attach monitoring sheets when submitting Seclusion and Restraint form.	☐ Yes, Date(s) of Completion: ☐ No (If no, explain):

FINAL SIGN-OFF
Name of Director of Nursing or Designee reviewing Seclusion and Restraint Documentation: *Click here to enter text.*
Director of Nursing or Designee Phone Number: *Click here to enter text.*
Date of Sign-off: *Click here to enter text.*
Time (24-hour clock) of Sign-off: *Click here to enter text.*

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